1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05479

CERTIFICATE OF DEATH

05477

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds
c. LENGTH OF STAY IN 1b: 55Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Montie — Middle: J — Last: Sanbower

4. DATE OF DEATH: Month: April — Day: 1st — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr 9th 1882

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired R R. Employe

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lovetsville, Va,

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Sanbower

14. MOTHER'S MAIDEN NAME: Emily E Cost

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grace S. Sanbower. Address: Boyds. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hepatitis, Cause undetermined.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 17 Feb, 19 62 to 1 April, 1967, that (I) ~~(we)~~ last saw the deceased alive on 24 Feb 1967, and that death occurred at 12:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Gordon Murdoch Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1 April 67

22c. PHYSICIAN'S NAME (Type): Gordon Murdoch Smith MD

22d. ADDRESS: Barnesville Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-4-67

23c. NAME OF CEMETERY OR CREMATORY: Taylortown

23d. LOCATION (City or Town) (County) (State): Taylortown. Va.

24. FUNERAL DIRECTOR: Ernest C Gartner — ADDRESS: Ernest C. Gartner. Gaithersburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge.

Dr John Bell to Consulted and approved T.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT. USE

05480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05479

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: Years.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4009 Bradley Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4009 Bradley Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Lee — Last: Scheffler

4. DATE OF DEATH: Month: April — Day: 29 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 23,1893

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed

10b. KIND OF BUSINESS OR INDUSTRY: Science

11. BIRTHPLACE (State or foreign country): Newark, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard Scheffler

14. MOTHER'S MAIDEN NAME: Myrtle Warthen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 217-36-7667

17. INFORMANT: Rita Derrick — Address: Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary insufficiency, acute — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardiovascular disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bethesda Maryland

22. DATE SIGNED: April 29, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 5-2-67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1SME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05481

CERTIFICATE OF DEATH

05478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda c. LENGTH OF STAY IN 1b: 33 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Md. 20014	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook d. STREET ADDRESS: 6922 100th Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Kurt	Leigh	Schilling	April	11	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		10 October 1954	12 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	---	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward L. Schilling, Jr.	Beverly Berkebile

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT The Medical Records — Address
No ---	None	The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Generalized Sepsis	1 week
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Generalized Hemorrhagic diathesis	1 week
DUE TO		
(c)	Acute Lymphocytic Leukemia	3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hepatosplenomegaly and generalized lymphadenopathy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 9, 19 67, to April 11, 19 67 that ☒ (we) last saw the deceased alive on April 11, 19 67, and that death occurred at 11:50 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
J. Rubenstein					12 April 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Joel J. Rubenstein, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	Apr. 15, 1967	Cedar Hill Crematory,	Suitland Maryland.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Don. DeVol	Wash. D.C. 2222 Wis. Ave. N.W.	APR 18 1967	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05482

CERTIFICATE OF DEATH

05480

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 45 hours

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: [illegible] Granville Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington Sanitarium and Hospital

3. NAME OF DECEASED (Type or print)	First	Middle	Lost
	Mabel	Case [illegible]	Schureman

4. DATE OF DEATH: Month: 4 — Doy: 25 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		5-30-04	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own home	New Jersey	U.S.A.

13. FATHER'S NAME: XXX Frederick Case

14. MOTHER'S MAIDEN NAME: Ida Capen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	217-36-6298	Shirley Christ	13801 Lionel Lane [illegible] Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Severe Coronary Arterio Sclerosis — 4 YEARS
DUE TO
(c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1954 to 4/28, 1967, that (I) (we) last saw the deceased alive on 4/28 1967, and that death occurred at 9:30 M, from causes and on the date stated above.

22a. SIGNATURE: A F Thibadeau MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/29/67

22c. PHYSICIAN'S NAME (Type): DR. A.F. THIBADEAU MD

22d. ADDRESS: Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 2, 1967	George Washington Cemetery	Adelphi, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John B. Thomas Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.	DATE MAY 4 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05483 — **CERTIFICATE OF DEATH** — 05483

Item #2c & d Film #6387 4/10/67 ps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 812 Bruce Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Daisy — Middle: Belle — Last: Scott

4. DATE OF DEATH: Month: April — Day: 1 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: Jan 17, 1897

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months: 2 — Days: 14

IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Payroll Clerk

11. BIRTHPLACE (County & State, or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Ford

14. MOTHER'S MAIDEN NAME: Ella Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 457-74-2463

17. INFORMANT — Address: 812 Brice Road: Clifford W. Scott - Son - Rockville, Maryl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial failure

DUE TO (b): Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/17 1966, to present, 19..., that (I) (we) last saw the deceased alive on 2/27 1967, and that death occurred at 12 M, from the causes and on the date stated above.

22a. SIGNATURE: John B. Umhau M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/1/67

22c. PHYSICIAN'S NAME (Type): John B. Umhau

22d. ADDRESS: 8805 Conn. Ave., Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/4/67

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven

23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funer l Home

ADDRESS: 1331 Rock. Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: APR 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jogge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05484 — 05482

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE:
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 2700 Conn. Avenue N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: FREDERIC — Middle: W — Last: SEIBOLD

4. DATE OF DEATH: Month: April — Day: 17 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/27/1876

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Custom House Broker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Louis P. Seibold

14. MOTHER'S MAIDEN NAME: Josephine Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 577-10-5039

17. INFORMANT: Helen T. Seibold - Address 4922 LaSalle Rd Hyattsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal Hemorrhage due to Diverticulitis
5721
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan., 19 66 to April, 19 67 that (I) (~~We~~) last saw the deceased alive on April 16, 19 67, and that death occurred 11:30A.M. from the causes and on the date stated above

22a. SIGNATURE: Thom F Collins M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Thomas F Collins, M.D.

22d. ADDRESS: 322 H St. N.E. Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4/20/67

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The S.H.Himes Company Washington,D.C.

25a. REC'D BY REGISTRAR DATE: APR 21 1967

25b. REGISTRAR'S SIGNATURE: Wesley Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05485

CERTIFICATE OF DEATH

05483

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 44 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 4511 EDGEFIELD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLARA — Middle: C. — Last: SESSO

4. DATE OF DEATH: Month: 4 — Day: 20 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-18-08

9. AGE (In years last birthday): 58 Yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Mt. Airy, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Alvin F. Conaway

14. MOTHER'S MAIDEN NAME: Bessie Leatherwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Husband — Joseph R. Sesso — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 mos
DUE TO (b): Carcinoma of liver and colon — 4mos/4yrs
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/17, 19 67 to 4/20, 19 67, that (I) (we) last saw the deceased alive on 4/19 19 67, and that death occurred at 9:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: Benne G. Bendler — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-20-67

22c. PHYSICIAN'S NAME (Type): BENNE G. BENDLER

22d. ADDRESS: 10820 GA. Ave Wheaton Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-25-67

23c. NAME OF CEMETERY OR CREMATORY: Alexandria Natl Cem.

23d. LOCATION (City or Town) (County) (State): Alexandria, Virginia

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05486

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05484

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.C.a.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Virginia — b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. STREET ADDRESS: 3212 Gillin Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Jack — Middle Seybold — Last Christman
4 DATE OF DEATH: Month April — Day 15 — Year 19 67

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-10-26
9 AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer
10b KIND OF BUSINESS OR INDUSTRY: Navair Eng.
11 BIRTHPLACE (State or foreign country): Washington, D.C.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: John Seybold
14 MOTHER'S MAIDEN NAME: Mary Christman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1943-1946
16 SOCIAL SECURITY NO
17 INFORMANT: Elder Wife — Address: Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Compound, Comminuted Fracture of Skull
DUE TO (b): Auto Accident.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Lost control of car ran off highway was thrown out & struck head
20c TIME OF INJURY Hour 1140 p.m. Month, Day, Year 4/14 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory street, office bldg. etc.): Highway #95
20f (City or town) Cabin John (County) Mont. (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)
22. DATE SIGNED: 4/15/67

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 4/19/67
23c NAME OF CEMETERY OR CREMATORY: Alexandria National Cemetery, Alexandria, Va.
23d LOCATION (City or Town) (County) (State)

24 FUNERAL DIRECTOR: The Demaine Funeral Homes, Inc.
ADDRESS: Alexandria, Va.
25a RECD BY REGISTRAR DATE: APR 18 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05487

CERTIFICATE OF DEATH

05485

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE: D.C. — b COUNTY: —
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda	c. LENGTH OF STAY IN 1b: 8 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 17.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban	d STREET ADDRESS: 325 Farragut St N.W. — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: Marcus	Middle: E	Last: Shapiro	4. DATE OF DEATH	Month: 4	Day: 27	Year: 1967	
5. SEX: M	6. COLOR OR RACE: W	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 2/1/89	9. AGE (In years last birthday): 78 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter	10b KIND OF BUSINESS OR INDUSTRY: Self Employed	11 BIRTHPLACE (County & State, or foreign country): Russia	12 CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME: Eugene Shapiro	14 MOTHER'S MAIDEN NAME: UNKNOWN							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16. SOCIAL SECURITY NO: 202-05-4189	17 INFORMANT: Address 8405 Ellingson Drive Bethesda Md.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Right Lobe Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 da
DUE TO (b): Chronic Dehydration — 2 wks
DUE TO (c): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21 I certify that (I) (this hospital) attended the deceased from Apr. 20, 1967, to Apr 27, 1967, that (I) (we) last saw the deceased alive on Apr 26 1967, and that death occurred at 6:5 p.m., from causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐		22b DATE SIGNED: 4-27-67
22c PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU	22d ADDRESS: ROCKVILLE MD. 20852	

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE THEREOF: 4-30-1967	23c NAME OF CEMETERY OR CREMATORY: GEO WASH. CEMETERY	23d LOCATION (City or Town): HYATTSVILLE	(County) (State): MD.
24 FUNERAL DIRECTOR: Goldberg Funeral Home	ADDRESS: 4217 9th St. N.W.	25a REC'D BY REGISTRAR DATE: MAY 1 1967	25b REGISTRAR'S SIGNATURE: Miranda Duke	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05488 Items #8 & 9 Film #[illegible] 05486

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1½ months

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15/1
d. STREET ADDRESS: 9801 Rosensteel Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Crosss Hospital

3 NAME OF DECEASED (Type or print): First: Thomas — Middle: J. — Last: Shea, Junior

4. DATE OF DEATH: Month: April — Day: 4 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: August 7, 1893

9. AGE (In years last birthday): 73 mo yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 72hrs
DUE TO
(b): Myeloproliferative Syndrome — 1 yr +
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gouty Nephropathy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966 to April 4, 1967, that (I) ~~(we)~~ last saw the deceased alive on April 3 1967, and that death occurred at 5:30 M, from causes and on the date stated above.

22a. SIGNATURE: James Wegan — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4/3/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 7

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d LOCATION (City or Town) (County) (State): Alexandria, VA.

24. FUNERAL DIRECTOR: Hanlon Funeral Home — ADDRESS: [illegible]

25a REC'D BY REGISTRAR — DATE APR 12 1967

25b REGISTRAR'S SIGNATURE: J. Charles Jusse

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05489

CERTIFICATE OF DEATH

05487

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4601 Sleaford Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: L — Last: Shoey

4. DATE OF DEATH: Month: April — Day: 13 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 11/30/87

9. AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Allegany Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Smith

14. MOTHER'S MAIDEN NAME: Margaut Park

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 194-01-8690

17. INFORMANT: Sister — Address: Jessie Smith — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive Heart Failure — Interval between onset and death: 7 days
DUE TO
(b): Arteriosclerotic Heart Disease — 2 yrs
DUE TO
(c): Generalized Arteriosclerosis — 10 yrs
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/1, 1966 to 4/13, 1967, that (I) (we) last saw the deceased alive on 4/12 1967, and that death occurred at 7:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Ronald Barr — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-13-67

22c. PHYSICIAN'S NAME (Type): RONALD W. BARR

22d. ADDRESS: 10401 Old Georgetown Rd Bethesda, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-15-67

23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d. LOCATION (City or Town) (County) (State): Westernport, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR: APR 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #351 7/31/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05488

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Dickerson
c. LENGTH OF STAY IN 1b: 10 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pepco Power Plant.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson
d. STREET ADDRESS: Route. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charley — Middle: Henry — Last: Sigatoose

4. DATE OF DEATH: Month: Apr. — Day: 18 — Year: 1967

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 24 1877

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist B&O RR.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin F Sigatoose

14. MOTHER'S MAIDEN NAME: Laura Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 705-12-3242

17. INFORMANT — Address: Mrs Robert Day - Dickerson, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Over-Exposure to cold - 0
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 9557
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PROBABLY or CONTRIBUTING CAUSE OF DEATH ☒

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Was over come when working on trash Pile.

20c. TIME OF INJURY Month, Day, Year: Hour a.m. ? p.m. 2/1 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Trash Pile

20f. (City or town) (County) (State): Dickerson Mont. MD

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 4/18/1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/22/67

23c. NAME OF CEMETERY OR CREMATORY: Lowden Park Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. C. Hilton, Barnesville, Md.

25a. RECD BY REGISTRAR DATE: APR 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

35490 — 05489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then release remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8409 DIXON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle STANLEY Last SIMMONS SR.
4. DATE OF DEATH: Month APRIL Day 15 Year 1967
5. SEX: M
6. COLOR OR RACE: Wh
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-6-93
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED (PAINTER)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH SIMMONS
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 578-01-7248
17. INFORMANT: SAMUEL S. SIMMONS, JR. 12116 VIERS MILL RD Address SILVER SPRING MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Emphysema, chronic — INTERVAL BETWEEN ONSET AND DEATH: Known 3 years.
5271
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease with Recent Coronary Thrombosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from April 13, 1967, to April 15, 1967, that (I) (we) last saw the deceased alive on April 14 1967, and that death occurred at 8:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Aaron H. Traum — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: April 15 1967
22c. PHYSICIAN'S NAME (Type): AARON H. TRAUM
22d. ADDRESS: 8237 Georgia Ave. Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/18/1967
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM
23d. LOCATION (City, town or county) (State): COLMAR MANOR, PRINCE GEORGES CO. MD

24. FUNERAL DIRECTOR: C. W. CHAMBERS, INC. ADDRESS: SILVER SPRING MD
25a. REC'D BY REGISTRAR DATE: APR 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05491

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: 5490 Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 309 Indian Spring Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lucy Middle B. Last Simms
4. DATE OF DEATH: Month April Day 7 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-16-84
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months 7 Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore Co. Balt. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Lichner
14. MOTHER'S MAIDEN NAME: Catherine Snyder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Washington Sanitarium & Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary heart attack
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 31, 1967, to April 7, 1967, that (I) (we) last saw the deceased alive on Apr. 7, 1967, and that death occurred at 2:42 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John N. Andrews — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/7/67
22c. PHYSICIAN'S NAME (Type): John N. Andrews
22d. ADDRESS: 9601 Colesville Rd Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 11-1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington Va.

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Capitol St N.W. Washington D.C.
25a. REC'D BY REGISTRAR DATE: APR 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Junge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05492 05491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 9603 Hillbridge Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMILIE Middle THOMSON Last SIMS
4. DATE OF DEATH: Month APRIL Day 4 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-31-86
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months 3 Days 5
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (County & State, or foreign country): OREGON
12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: ROBERT THOMSON
14. MOTHER'S MAIDEN NAME: MARGARET CROCKETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: (CHART) Address: Robt. T. Homer 18447 Harlow St. Detroit, Mich.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH
1990
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from January, 1967, to 4-4, 1967, that (I) ~~(we)~~ last saw the deceased alive on 4-4 1967, and that death occurred at 12 P.M., from causes and on the date stated above.

22a. SIGNATURE: Stuart L Nelson M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-4-67
22c. PHYSICIAN'S NAME (Type): STUART L. NELSON
22d. ADDRESS: 831 University Blvd. E. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 4-7-1967
23c. NAME OF CEMETERY OR CREMATORY: Baptist Church Cem.
23d. LOCATION (City or Town) (County) (State): Beaufort, S.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.
ADDRESS: 5130 Wisc. Ave. N.W. Wash. DC.
25a. REC'D BY REGISTRAR DATE APR 10 1967
25b. REGISTRAR'S SIGNATURE: Winston Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05493

CERTIFICATE OF DEATH

05492

1 PLACE OF DEATH
a. COUNTY: Montgomery Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Valley Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
e. STREET ADDRESS: 4525 Jamestown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Martin — Middle: A.K. — Last: Slack

4. DATE OF DEATH: Month: April — Day: 15 — Year: 1967

5. SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: July 21 1892

9 AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road.

11 BIRTHPLACE (County & State, or foreign country): New London Conn.

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Slack

14. MOTHER'S MAIDEN NAME: Minnie (Unknown)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 705-18-4259

17. INFORMANT: A. Carstens Slack — Address: WASH, DC 20016 — 4525 Jamestown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hepatic Coma	3 days
DUE TO (b)	Metastatic Ca of Liver	6 mos
DUE TO (c)	Adeno Ca of rectum	1 year

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 1, 1967, to April 15, 1967 that (I) (we) last saw the deceased alive on April 15 1967, and that death occurred at 2:30 P.M., from causes and on the date stated above.

22a SIGNATURE: C.R. Gruver — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: April 15 1967

22c. PHYSICIAN'S NAME (Type): C.R. Gruver

22d. ADDRESS: 915 19th St NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.

23d LOCATION (City or Town) (County) (State): Brooklyn, L.I. N.Y.

24 FUNERAL DIRECTOR — **ADDRESS**: Joseph Gawler's Sons, Inc. Wash., D.C.

25a. FILED BY REGISTRAR — **DATE**: APR 21 1967

25b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 F.H. 3-27-67 4/11/67 KK

05494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05493

1 PLACE OF DEATH
a COUNTY: Mont. Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 1 Yr.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a STATE: Md. — b COUNTY: Mont. Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
d STREET ADDRESS: R.F.D. #1
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Myrtle — Middle: L. — Last: Slater

4 DATE OF DEATH: Month: 4 — Day: 2 — Year: 19 67

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 2/24/89
9 AGE (Last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Levin Thomas.
14 MOTHER'S MAIDEN NAME: Hetta Trundle.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): no
16 SOCIAL SECURITY NO: Unknown
17 INFORMANT: Mary Anne Bell — Address: Same As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Chronic mitral valvular stenosis
DUE TO (c): Chronic rheumatic mitral valvulitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 410 X
INTERVAL BETWEEN ONSET AND DEATH: years / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus, hypostatic bronchopneumonia, terminal.

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or Town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bethesda, Md.
22. DATE SIGNED: 4/3/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4-5-67
23c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a REC'D BY REGISTRAR DATE: APR 7 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05495

CERTIFICATE OF DEATH

05494

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 21 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ashton
d. STREET ADDRESS: 17400 New Hampshire Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Elanor — Middle: Louise — Last: Smith

4 DATE OF DEATH: Month: April — Day: 25 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: July 18, 1885
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Smith
14 MOTHER'S MAIDEN NAME: Sarah Amoss

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 20 Days
DUE TO (b): CEREBRAL ARTERIOSCLEROSIS — 4 Yrs.
DUE TO (c): GENERAL ASCVD — Yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): TOXIC ENCEPHALOPATHY - ETHANOLIC - CORONARY SCLEROSIS
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 1963, to 25 Apr, 1967, that (I) (we) last saw the deceased alive on 24 Apr 1967, and that death occurred at 1:10 a.m. p.m. from causes and on the date stated above.

22a SIGNATURE: Ronald P. Lewis — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4/25/67
22c PHYSICIAN'S NAME (Type): Ronald R. Lewis
22d ADDRESS: Sandy Spring, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Delivered to Georgetown University - Anatomy Dept. for Scientific Purposes
23b. DATE THEREOF: 4/25/67
23c NAME OF CEMETERY OR CREMATORY:
23d LOCATION (City or Town) (County) (State):

24 FUNERAL DIRECTOR: B.R. Bhussry, Chairman — ADDRESS:
25a RECD BY REGISTRAR DATE: APR 27 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05496

CERTIFICATE OF DEATH

05495

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Glenna — Middle: Pearl — Last: Smith

4. DATE OF DEATH: Month: 4 — Day: 7 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/22/08

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sherwood Duvall

14. MOTHER'S MAIDEN NAME: Verdie Roller Fulk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: Hospital Records, Olney, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma, Breast — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1966 to 4-7, 19 67, that (I) (we) last saw the deceased alive on 4-7 1967 and that death occurred at 11:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-7-67

22c. PHYSICIAN'S NAME (Type): Jack Schumacher

22d. ADDRESS: 105 Russell Ave., Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Neelsville

23d LOCATION (City or Town) (County) (State): Germantown, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.

25a. REC'D BY REGISTRAR: DATE APR 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05497

CERTIFICATE OF DEATH

05496

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   c. LENGTH OF STAY IN 1b: 18 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
   d. STREET ADDRESS: 5223 Meadowview Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Guy — Middle: Robert — Last: Smith

4. **DATE OF DEATH**: Month: 4 — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-2-95

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night sup. maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Capitz Building

11. BIRTHPLACE (County & State, or foreign country): PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Smith

14. MOTHER'S MAIDEN NAME: Lucinfilena Armghast

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 14 days
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Widespread metastases - Bronchogenic carcinoma — 1 month
   DUE TO
   (c): Bronchogenic carcinoma — years

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ① ASHD ② Hypostatic pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/25, 1967, to 4/1, 1967 that (I) (we) last saw the deceased alive on 4/1 1967, and that death occurred at 3:30 M, from causes and on the date stated above

22a. SIGNATURE: Kenneth Cruz M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/1/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-2-1967

23c. NAME OF CEMETERY OR CREMATORY: Reno Cemetery

23d. LOCATION (City or Town) (County) (State): Reno Pennsylvania

24. FUNERAL DIRECTOR: Robert E. Wilhelm Funeral Home — ADDRESS: 4308 Suitland Rd Suitland Maryland

25a. REC'D BY REGISTRAR — DATE: APR 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05498 05497

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c LENGTH OF STAY IN b: 5 hr. 40 min.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Michigan
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Battle Creek
d. STREET ADDRESS: 131 Boyes Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Robert Eugene — Middle: — Last: SMITH
4 DATE OF DEATH: Month: April — Day: 18 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: Cauc.
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Dec. 19, 1946
9 AGE (In years last birthday): 20 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Battle Creek, Michigan
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Norman Daniel Smith
14 MOTHER'S MAIDEN NAME: Katherine Tabiadon

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): ACTIVE DUTY
16 SOCIAL SECURITY NO: 376 48 4016
17 INFORMANT: Navy Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Multiple injuries, severe — INTERVAL BETWEEN ONSET AND DEATH: 11 hr.
DUE TO (b): Automobile accident — 11 hr.
DUE TO (c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Lost control of car, struck hydrant and was thrown out of car
20c TIME OF INJURY Month Day Year: Hour o'm. 8:55 p.m. 17 Apr 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home farm factory, street office bldg., etc.): Street
20f (City or Town) (County) (State): Naval Air Station Patuxent River, Md.

21 I certify that I took charge of the remains described above held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 18 April 196

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4/20/67
23c NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d LOCATION (City or Town) (County) (State): Battle Creek, Michigan

24 FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: 1400 Chapin St., N.W. Washington, D. C.
25a RECD BY REGISTRAR DATE: APR 20 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05493 05498

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 3 3/mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Randolph Hills Nursing Home.

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 12034 Valleywood
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: H — Last: Smith

4. DATE OF DEATH: Month: Apr. — Day: 11 — Year: 1967

5. SEX: m

6. COLOR OR RACE: w

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

8. DATE OF BIRTH: Jan. 31, 1901

9. AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glazer

10b. KIND OF BUSINESS OR INDUSTRY: Glass

11. BIRTHPLACE (County & State, or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 579-03-5370A

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.
DUE TO
(b): Carcinoma. rt. Kidney — 1 yr.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-22, 1967, to 4/10, 1967, that (I) (we) last saw the deceased alive on 4/4 1967, and that death occurred at 12 01 M, from causes and on the date stated above.

22a. SIGNATURE: Dame L Coleman MD — M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: April 11, 1967

22c. PHYSICIAN'S NAME (Type): JAMES R. COLEMAN MD

22d. ADDRESS: 9241 COLUMBIA BLVD SILVER SPRING Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4/14/67

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Montgomery Co. Md.

24. FUNERAL DIRECTOR: H. T. Huntsman — ADDRESS:

25a. REC'D BY REGISTRAR DATE: APR 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

Signed by medical examiner. J. Coleman M.D. 90

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05500 — 05499

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Michigan — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 11 min.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oak Park

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

d. STREET ADDRESS: 8539 Capital Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stuart — Middle: Gratton — Last: SNELL

4. DATE OF DEATH: Month: April — Day: 7 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1946

9. AGE (In years last birthday) yrs: 20

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Bluefield, West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Ann Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service): Yes 1-18-66- 4-7-67

16. SOCIAL SECURITY NO: 382 46 2351

17. INFORMANT — Address: Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Laceration and maceration of brain — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

DUE TO (b): Trauma from auto accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Lost control of car, hit median strip & turned over.

20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m.: 1:45 p.m. 4/7 1967

20d. INJURY OCCURRED White at work ☐ Not White at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Bethesda Mont. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒; and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Bethesda, Md.

22. DATE SIGNED: 7 Apr. 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 4/7/67

23c. NAME OF CEMETERY OR CREMATORY: WOODMERE

23d. LOCATION (City or Town) (County) (State): DETROIT, MICH

24. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co., 1400 Chapin Street, N.W. Washington, D. C.

25a. REC'D BY REGISTRAR — DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 7/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05500

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN To
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9700 Mt. Pisgah Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CARL — Middle WILLIAM — Last SNIDER SR

4 DATE OF DEATH: Month April — Day 21 — Year 1967

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8/9/91

9 AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Retired)

10b KIND OF BUSINESS OR INDUSTRY: Home Construction

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: William Peter Snider

14. MOTHER'S MAIDEN NAME: ANNIE Caylor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 578-05-5002

17 INFORMANT — Address: Ruth Snider 9700 Mt Pisgah Rd., S.S.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial Dis. — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Chronic Myocardial Dis. — 4 yrs
DUE TO (c): Generalized Arteriosclerosis — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, Fractured Hip

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell at Nursing Home

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: April 5, 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Nursing Home

20f (City or town) (County) (State): Silver Spring Montgomery Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Rogers M.D.

EXAMINER'S NAME (Type): John S. Rogers M.D.

Address (Street, city, town, or county): 178 Seminary Rd, Silver Spring

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4-21-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 4-25-67

23c. NAME OF CEMETERY OR CREMATORY: George Washington Memorial Park

23d. LOCATION (City or Town) (County) (State): Rigas Rd Ext Prince Geo Co, Md

24. FUNERAL DIRECTOR: W.W. Chambers Co — ADDRESS: Silver Spring Md

25a REC'D BY REGISTRAR DATE: APR 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05502 05501

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton Silver Spring
c. LENGTH OF STAY IN 1b: 3 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10208 Carson Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen Middle: Loretta Last: Snyder
4. DATE OF DEATH: Month, Day, Year: 4/2/1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12/29/1902
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Raleigh Haberdasher
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frederick Day
14. MOTHER'S MAIDEN NAME: Mary ~~xxx~~ Brusick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no None
16. SOCIAL SECURITY NO: 579-01-2417
17 INFORMANT: Kenneth Day-2 Park Dr., ~~xxxxxxx~~ Belmawr, N. J.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Liver failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Metastatic melanoma of liver — 6 mo
DUE TO (c): Malignant melanoma, right conjunctiva — 9 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 18, 1967, to April 2, 1967, that (I) (we) last saw the deceased alive on April 2, 1967, and that death occurred at 6:40 P.M., from causes and on the date stated above

22a. SIGNATURE: Raymond Bradshaw, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-3-67
22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw, M. D.
22d. ADDRESS: 345 University Blvd., W. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wash. Nat'l Memorial Park
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: John B. Thomas Funeral Home / Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: APR 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Jaeger

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05503

CERTIFICATE OF DEATH

05502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Box 107 R#3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Preston — Middle: Lincoln — Last: Snyder

4. **DATE OF DEATH**: Month: April — Day: 16 — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/27/1885

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Montgomery - Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Leonard Snyder

14. MOTHER'S MAIDEN NAME: Sennie E. Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 217-36-6743

17. INFORMANT — Address: Mrs. Carol W. Snyder - daughter

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular accident - thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral arteriosclerosis — 10 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-4- , 1967 to 4-16- , 1967, that (I) (we) last saw the deceased alive on 4-15- 1967, and that death occurred at 5/16 P.M. from causes and on the date stated above.

22a. SIGNATURE: Stephen W. DeJter — MD — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): STEPHEN W. DEJTER, M.D.

22d. ADDRESS: 6719 Wilson La., Bethesda, MD 20034

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bethesda Meth.

23d. LOCATION (City or Town) (County) (State): Brookeville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.

25a. RECD BY REGISTRAR DATE: APR 19 1967

25b. REGISTRAR'S SIGNATURE: Atlantes Judge

Items 18-21 Film 390 6-23

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05503

1 PLACE OF DEATH
a COUNTY: Montgomery
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c LENGTH OF STAY IN 1b: 9 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10600 Lilac St.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10600 Lilac St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ruby Middle: Marie Last: Sommers

4 DATE OF DEATH: Month: 4 Day: 29 Year: 1967

5 SEX: Female

6 COLOR OR RACE: white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 3-8-22

9 AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cryptanalyst

10b KIND OF BUSINESS OR INDUSTRY: ~~N.S.A.~~ N.S.A.

11 BIRTHPLACE (State or foreign country): Roanoke, Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Earl Johnson

14 MOTHER'S MAIDEN NAME: Mary Will Scott

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 226-14-2704

17. INFORMANT: William Sommers
Address: 10611 Lilac Place Silver Spring, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Asphyxiation due to strangulation
DUE TO
(b): with venetian blind cord
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 974.X

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Hanged self in basement of home.

20c TIME OF INJURY Month Day, Year: Hour 2:00 pm 4-29 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) (County) (State): Silver Spring Montg Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
Address (Street, City, Town or county): Wheaton

22. DATE SIGNED: 4/30/1967

23a BURIAL CREMATION, REMOVAL (Specify): Trans-burial

23b DATE THEREOF: May 3, 1967

23c NAME OF CEMETERY OR CREMATORY: Sherwood Cemetery

23d LOCATION (City or Town) (County) (State): Roanoke, Virginia

24 FUNERAL DIRECTOR: John B. Thomas
Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a RECD BY REGISTRAR DATE: MAY 4 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05503

CERTIFICATE OF DEATH

05504

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 12 hrs. 24 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 71 Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XX Gaithersburg
d. STREET ADDRESS: RFD 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jeffrey — Middle: Ray — Last: Stachura

4. DATE OF DEATH: Month: April — Day: 24, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-23-67

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months — Days: 12 — IF UNDER 24 HRS.: Hours — Min.: 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ernest Stachura, Sr.

14. MOTHER'S MAIDEN NAME: Myrtle Louise Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Father - same item #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Atelectasis of Newborn
7620
DUE TO (b): Respiratory Distress of newborn
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Congenital Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: H.H. Diamond M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): H. H. DIAMOND

22d. ADDRESS: 911 - Silver Spring ave Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/27/67

23c. NAME OF CEMETERY OR CREMATORY: Darnestown

23d. LOCATION (City or Town) (County) (State): Darnestown Montg. Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: Rock. Pike Rockville, Md.

25a. REC'D BY REGISTRAR — DATE: APR 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

7-20-26

1 (M)

05506

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05505

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 228 Sharey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Marjorie Middle: B Last: Steffen
4. DATE OF DEATH Month Day Year: 27, Apr, 67 19

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1/24/00
9. AGE (In years last birthday) 67 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (County & State, or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Cross
14. MOTHER'S MAIDEN NAME Mary Glover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) None
16. SOCIAL SECURITY NO. Yes
17. INFORMANT Jim Steffen Address 228 Sharey Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease manifest by
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) 1. Acute postero-septal myocardial infarct
DUE TO (c) 2. Coronary atherosclerosis. severe
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
congestion and edema of lungs
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4/3, 1967, to 4/27, 1967, that (I) ~~(we)~~ last saw the deceased alive on 4/25 1967, and that death occurred at 5:40 A M, from causes and on the date stated above.

22a. SIGNATURE G. Leonard Gold M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 4/27/67
22c. PHYSICIAN'S NAME (Type) G. Leonard Gold
22d. ADDRESS 8641 Colesville Rd., S. S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial
23b. DATE THEREOF May 1, 1967
23c. NAME OF CEMETERY OR CREMATORY Fairhaven Cemetery
23d. LOCATION (City or Town) (County) (State) Santa Ana, California

24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE MAY 1 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health; prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner L. Mc.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05507

CERTIFICATE OF DEATH

05506

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 808 OLIVE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: SOPHIA — Last: STEPHENS
4. DATE OF DEATH: Month: 4 — Day: 26 — Year: 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-25-74
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM J. BOWEN
14. MOTHER'S MAIDEN NAME: SOPHIA E. LATHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 219-54-8156
17. INFORMANT: MEDICAL RECORDS DEPT. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — yrs.
DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-25, 1967, to 4-26, 1967, that (I) (we) last saw the deceased alive on 4-25 1967, and that death occurred at 9 A.M., from causes and on the date stated above.

22a. SIGNATURE: Frederick Moomau M.D. — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-26-67
22c. PHYSICIAN'S NAME (Type): FREDERICK MOOMAU M. D.
22d. ADDRESS: MEDICAL CENTER, SANDY SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 4/28/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): Portsmouth, Virginia

24. FUNERAL DIRECTOR: S.H. Hines Co. — ADDRESS: 2901 14th NW D.C.
25a. REC'D BY REGISTRAR DATE: APR 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05508 — 05507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [illegible] newspapers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Affirmed by acting Coroner, Montgomery, Md.

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 9506 Garwood Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: HOY — Middle: — Last: STEVENS

4. **DATE OF DEATH**: Month: April — Day: 22 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/21/96

9. AGE (In years last birthday): 71 yrs
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Automotive Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Dept of Commerce

11. BIRTHPLACE (County & State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY?: U. S.A.

13. FATHER'S NAME: Dale O. Stevens

14. MOTHER'S MAIDEN NAME: Louanna H. Hoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): World War I

16. SOCIAL SECURITY NO: 272-03-0519-A

17. INFORMANT: Address: Sil. Sp., Md. — Mrs. Avis C. Stevens - 9506 Garwood St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b): Hypertensive arteriosclerotic heart
   DUE TO (c): disease & auricular fibrillation — Years

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Mar 15, 1966 to April, 1967, that (I) (~~we~~) last saw the deceased alive on April 15 1967, and that death occurred at 4:52 M, from causes and on the date stated above

22a. SIGNATURE: Sydney Leventhal, M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4/22/67

22c. PHYSICIAN'S NAME (Type): Sydney Leventhal, M.D

22d. ADDRESS: Silver Spring Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: Apr 25, 1967

23c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery

23d. LOCATION (City or Town) (County) (State): Lakewood, Ohio

24. FUNERAL DIRECTOR: John B. Thomas — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR: DATE: 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

Item 21 Film 388 4-24-67 a

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05509

CERTIFICATE OF DEATH

05508

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 63 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 15 East Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Elmer — Last: Stine III

4. DATE OF DEATH: Month: April — Day: 5 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 16, 1940

9. AGE (In years last birthday): 27

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory worker

10b. KIND OF BUSINESS OR INDUSTRY: Optical Instruments

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George E. Stine, Jr.

14. MOTHER'S MAIDEN NAME: Ruth Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-36-3415

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Tamponade — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Pericardial Effusion — 4 months
DUE TO
(c): Hodgkin's Disease — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 1[illegible] 19 67, to April 5, 19 67 that (I) (we) last saw the deceased alive on April 5 19 67, and that death occurred at 3:40 P.M., from causes and on the date stated above.

22a. SIGNATURE: C. Kierney — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5 April 1967

22c. PHYSICIAN'S NAME (Type): Carl Kierney, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 10-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): Frederick, Md. 21701

24. FUNERAL DIRECTOR: M.R.Etchison & Son — ADDRESS: Edward Whitmore Frederick, Md.21701

25a. REC'D BY REGISTRAR DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05510

CERTIFICATE OF DEATH

05509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c LENGTH OF STAY IN 1b: 3/16/67-4/27/67
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Md. — b COUNTY: Mont. P.G.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
d STREET ADDRESS: 804 Jackson Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Mrs. Missouri — Middle: Ann — Last: Stock
4 DATE OF DEATH: Month: 4 — Day: 27 — Year: 1967

5 SEX: F
6. COLOR OR RACE: White
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-24-68
9 AGE (In years last birthday): 98 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b KIND OF BUSINESS OR INDUSTRY: ~~Indoor~~
11. BIRTHPLACE (County & State, or foreign country): Indiana
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles J. Cady
14 MOTHER'S MAIDEN NAME: Mary E Spellman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 577-68-6992-T
17 INFORMANT: Mr. Harry Stock — Address: 7667 Maple Ave T.P.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Chronic degenerative myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Oct 2, 1945
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): c frequent spells of decompensation to 4/27/68
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/2/45, 19 to 4/27, 1967 that (I) (we) last saw the deceased alive on 4/27 1967, and that death occurred at P.M. from causes and on the date stated above.

22a SIGNATURE: Howard T Morse M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 4/27/67
22c PHYSICIAN'S NAME (Type): HOWARD T. MORSE
22d ADDRESS: 7030 CARROLL AVE TAK PK MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 1. 1967
23c NAME OF CEMETERY OR CREMATORY: Stephens Cemetery
23d LOCATION (City or Town) (County) (State): Lewisville Vge. Co. Indiana

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Carroll St. N.W. Washington D.C.
25a REC'D BY REGISTRAR ☑ DATE: MAY 1 1967
25c REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05511

CERTIFICATE OF DEATH

05510

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b: 1hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 5506 75th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry Middle: Edward Last: Straw

4. DATE OF DEATH: Month: 4 Day: 6 Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/12/07

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engr

10b. KIND OF BUSINESS OR INDUSTRY: Country Club

11. BIRTHPLACE (County & State, or foreign country): Herndon Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aaron Straw

14. MOTHER'S MAIDEN NAME: Annie Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W W II

16. SOCIAL SECURITY NO:

17. INFORMANT: Wife Address: Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute cardio-circulatory collapse
DUE TO (b): Acute myocardial infarction
DUE TO (c): Coronary artery arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1967 to April 6, 1967 that (I) (we) last saw the deceased alive on April 6 1967, and that death occurred at 12:13 PM, from causes and on the date stated above.

22a. SIGNATURE: R Franchi M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4/6/67

22c. PHYSICIAN'S NAME (Type): RU FRANCHI

22d. ADDRESS: 7729 Finn's Lane Lanham Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Colmar Manor, Pro Geo Md.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: M Chandler Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05511

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 Hr. 10 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 501 S. Frederick Ave apt 20
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: — Last: Sutherland

4 DATE OF DEATH: Month: April — Day: 5 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov 29. 1906

9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineering

10b KIND OF BUSINESS OR INDUSTRY: Designer

11 BIRTHPLACE (State or foreign country): Aberdeen. Scotland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: James

14 MOTHER'S MAIDEN NAME: Agnes Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO: 055-10-9772

17. INFORMANT: Wife. Margaret Sutherland
Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Aneurysm, abdominal aorta ruptured with exsanguination.
DUE TO (b): Due to generalized arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate
(b) Years
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Bell M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4/6/67

Address (Street, city, town, or county)

23a BURIAL, CREMATION, REMOVAL (Specify): Removal

23b DATE THEREOF: 4-6-1967

23c NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d LOCATION (City or Town) (County) (State): Brooklyn N.Y.

24 FUNERAL DIRECTOR ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W., Wash. D.C.

25c REC'D BY REG STRAR: APR 11 1967

25d REGISTRAR'S SIGNATURE: Charles Jung

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05513 — 05512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10511 Malone St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: C — Last: Swiger

4. DATE OF DEATH: Month: April — Day: 18 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 24 1877

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Powhatan Sellings

14. MOTHER'S MAIDEN NAME: Sarah Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 218-54-7940

17. INFORMANT: Vernon Swiger — Address: 10511 Malone Street, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 20yrs
DUE TO (c): Senility — 20yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4438

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. / p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Jan, 1960, to April 18, 1967, that (I) ~~(we)~~ last saw the deceased alive on 4-17-1967, and that death occurred at 10:35 AM from causes and on the date stated above

22a. SIGNATURE: George B Patrick Jr M.D.
ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-18-67

22c. PHYSICIAN'S NAME (Type): George B. Patrick, JR MD

22d. ADDRESS: 9221 Colesville Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bluemont Cemetery

23d. LOCATION (City or Town) (County) (State): Grafton, West Virginia

24. FUNERAL DIRECTOR: Carter-Olson Co. — **ADDRESS**: 4324 Georgia Avenue
Turner E. Murphrey, Jr. Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05514

CERTIFICATE OF DEATH

05513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4700 Maple Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4700 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIAN Middle EVERETT Last TAPP

4. DATE OF DEATH: Month April Day 10, Year 19 67

5. SEX: Male ~~xXxxxxx~~

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12, 1905 ~~1907~~

9. AGE (In years last birthday): ~~99~~ 61 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Gov't.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Julian E. Tapp, Sr.

14. MOTHER'S MAIDEN NAME: Margaret Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-44-0146

17. INFORMANT Address: Catherine U. Tapp-Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN.
DUE TO
(b): HYPERTENSION — 4 YR.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-17, 1956, to 4-10, 1967, that (I) (we) last saw the deceased alive on MAR. 17 1967, and that death occurred at 8:10 M. from causes and on the date stated above

22a. SIGNATURE: Leo M. Curtis M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-11-67

22c. PHYSICIAN'S NAME (Type): Leo M. Curtis

22d. ADDRESS: 8218 Wis. Ave., Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/67

23c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens

23d. LOCATION (City or Town) (County) (State): Arlington, Va.

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #3 S 3/11/67 ps

05515

CERTIFICATE OF DEATH

05514

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MD. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SISTERS of HOLY CROSS

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7200 14th. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First IDA — Middle H. — Last TAYLOR

4. DATE OF DEATH: Month APRIL — Day 30 — Year 19 67

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-22-91

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: 577-10-8920-D

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: ROBERT P. HOLLAND

14. MOTHER'S MAIDEN NAME: LAURA A. TIMBERLAKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: GLADYS M. TAYLOR (DAUGHTER) Address: See Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coma due to CVA. — Interval between onset and death: 30 days
DUE TO (b): Hypertensive Vascular disease — 2 months.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
35 IX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pulmonary emphysema.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31, 1967, to 4/30, 1967, that (I) (we) last saw the deceased alive on 4/29 1967, and that death occurred at 10 A M, from causes and on the date stated above.

22a. SIGNATURE: James R Coleman M.D. — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/30/67

22c. PHYSICIAN'S NAME (Type): JAMES R COLEMAN

22d. ADDRESS: 9241 COLUMBIA BLVD SILVER SPRING. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-3-1967

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR: Jos. Gawler Sons — ADDRESS: Washington D.C.

25a. REC'D BY REGISTRAR DATE: MAY 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Juego

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05516

CERTIFICATE OF DEATH

05515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 1HR 20MIN
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 7604 Bells Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEARON — Middle: F — Last: TAYLOR

4. DATE OF DEATH: Month: APRIL — Day: 17 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-19-19

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF EMPLOYED.

10b. KIND OF BUSINESS OR INDUSTRY: Builder

11. BIRTHPLACE (County & State, or foreign country): Dauble Springs, Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OSCAR HARRISON TAYLOR

14. MOTHER'S MAIDEN NAME: CLAUDIA LYLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 422-12-6163

17. INFORMANT: CECIL O. TAYLOR (brother) Address: 7617 CARTER CT. BETHESDA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY OCCLUSION — 12 hours
DUE TO (c): CORONARY SCLEROSIS —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JAN. , 19 56, to APRIL 17 , 1967, that (I) (we) last saw the deceased alive on APRIL 17 1967, and that death occurred at 1:20 A M, from causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4/17/67

22c. PHYSICIAN'S NAME (Type): ROBERT G. ANGLE

22d. ADDRESS: 5009 Del Ray Ave. Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-21-67

23c. NAME OF CEMETERY OR CREMATORY: New Prospect Cem.

23d. LOCATION (City or Town) (County) (State): Jasper, Alabama.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Roberta Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05516

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 min.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San & Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a STATE: Maryland
b COUNTY: Prince George
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d STREET ADDRESS: 5800 Quebec St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Stephen Middle David Last Taylor

4 DATE OF DEATH: Month 4 Day 15 Year 1967

5 SEX: male
6 COLOR OR RACE: white
7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-08-47
9 AGE (In years last birthday): 19 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cable Splicer
10b KIND OF BUSINESS OR INDUSTRY: C & P Tel Co.
11 BIRTHPLACE (State or foreign country): Wash D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Raymond V. Taylor
14. MOTHER'S MAIDEN NAME: Mary G Johnstone

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 579-64-1185
17 INFORMANT: Wallet — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries, Severe — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Trauma from auto accident — 20 min.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PROBABLY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18): Lost control of his car and hit a Pole
20c TIME OF INJURY Month, Day, Year, Hour: 1:35 p.m. 4/15 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home farm factory, street office bldg., etc.): Highway
20f (City or town) Arde/Phia (County) Prince George (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 4/15/67

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 4/19/67
23c NAME OF CEMETERY OR CREMATORY: Baltimore Natl. Cem.
23d LOCATION (City or Town) Baltimore (County) (State) Md.

24 FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS: Mt. Rainier, Maryland
25a RECD BY REGISTRAR DATE: APR 20 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05518

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05517

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: VIRGINIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
d. STREET ADDRESS: M&S CO, TBS, QUANTICO, VA.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Mack	(NMN)	THACKER	April	9	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	Cauc		23 April 1943	23 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
USMC	MILITARY	Pikeville, Kentucky	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Manuel Ervin Thacker	Versie Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address	
Yes	404 58 6286	Mrs Karolyn Jean Thacker	1150 Lake Shore Blv Akron, ohio

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Severe head injury
DUE TO
(b): Auto accident
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
	Passenger in car that went out of control + crashed into another car.			
20c TIME OF INJURY Month, Day, Year: 3:40 a.m. p.m. 8 APRIL 19 67	20d INJURY OCCURRED While at work ☐ Not While at work ☒	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Highway 95	20f (City or town)	(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 4/10/67

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4/12/67	Rose Hill Cemetery	Akron		Ohio

24 FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. W. Chambers Co. 1400 Chapin St., N. W., Washington, D. C.	APR 12 1967	J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05519

CERTIFICATE OF DEATH

05518

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — LENGTH OF STAY IN 1b: D.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Dist. of Col. — b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4714-30th. St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

99

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Thomas
4. DATE OF DEATH: Month: April — Day: 28 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/14/92
9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Masonry Contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George Thomas.
14. MOTHER'S MAIDEN NAME: LEE Snow
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Robert Thomas — Address: 9905-Rockville Pike, Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Myocardial Infarction
DUE TO (c): Arteio-sclerotic Cardio-Vascular.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 1965, 19__ to 4/28, 1967, that (I) (~~he~~) last saw the deceased alive on 4/28 1967, and that death occurred at 8:?? M, from causes and on the date stated above.

22a. SIGNATURE: Robert Kramer — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-28-67
22c. PHYSICIAN'S NAME (Type): ROBERT KRAMER
22d. ADDRESS: 8484 16th ST. SS. Md 20910

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/1/67
23c. NAME OF CEMETERY OR CREMATORY: Parklawn
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: Joseph Sanders — ADDRESS: Sois Washington D.C.
25a. REC'D BY REGISTRAR: DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05520

CERTIFICATE OF DEATH

05519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Monta
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville, Md.
d. STREET ADDRESS: Box 65
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Gambrill — Last: Titus

4. DATE OF DEATH: Month: April — Day: 17 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec 12-19[illegible]

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Monta Co Government Employee

10b. KIND OF BUSINESS OR INDUSTRY: A.A.A.E. Dept.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Frank Titus

14. MOTHER'S MAIDEN NAME: Annie Fraze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-03-2495

17. INFORMANT Address: Mrs Betty Titus, Poolesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): uncle
DUE TO (b): Carcinoma of the left Tonsil
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a m / p m — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 14, 19[illegible], to 17 April, 1967, that (I) (we) last saw the deceased alive on 16 April 1967, and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: Chas Fawcett M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Boyds - Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/19/67

23c. NAME OF CEMETERY OR CREMATORY: Monocacy

23d. LOCATION (City or Town) (County) (State): Beallsville Monta Md

24. FUNERAL DIRECTOR: William C. Hilton

ADDRESS: Barnesville, Md.

25a. REC'D BY REGISTRAR DATE: APR 20 1967

25b. REGISTRAR'S SIGNATURE: J Charles Jacobs

1

25521

*Dr. John Ball released the body 4-14-67 to me [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1918 Carmody Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1918 Carmody Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Edwin — Middle: Joseph — Last: Tolker

4. DATE OF DEATH: Month: April — Day: 14 — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Nov 27, 1912

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Owner

10b. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alvin Tolker

14. MOTHER'S MAIDEN NAME: Rosa Heeke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO: 216-05-2320

17. INFORMANT: Mattie E. Tolker — Address: 1918 Carmody Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes
DUE TO (b): Coronary Arteriosclerosis — 10 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Jan, 1950, to April 14, 1967, that (I) ~~(saw)~~ last saw the deceased alive on 4-7-1967, and that death occurred at 1205 A.M., from causes and on the date stated above.

22a. SIGNATURE: George B Patrick Jr — M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): George B. Patrick, Jr. M.D.

22d. ADDRESS: 9221 Colesville Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr 17, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24a. FUNERAL DIRECTOR: Glen Carter Glen Carter Warren E. Murphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: APR 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

95522

CERTIFICATE OF DEATH

05521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN + HOSP

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8905 GLENVILLE RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FRANK Middle THATCHER Last TURNER

4 DATE OF DEATH: Month 4 Day 9 Year 19 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-22-06

9 AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DIST TELEGRAPH

10b KIND OF BUSINESS OR INDUSTRY: Co. Dist. Supt.

11 BIRTHPLACE (County & State, or foreign country): OHIO

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: HARRY TURNER.

14. MOTHER'S MAIDEN NAME: MARY THATCHER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 070-05-4499

17 INFORMANT: ~~XXXXXXXX~~ Evelyn Turner. Address: 8905 Glenville Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Acute Pneumonia — 1 day
DUE TO
(c): Acute Aplastic Anemia - Pancytopenia — 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mild Diabetes ; Hypertension

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 2, 1967, to April 9, 1967, that (I) (we) last saw the deceased alive on April 9 1967, and that death occurred at 9:30 PM, from causes and on the date stated above

22a SIGNATURE: Wilford D. Meyers M.D.
MD ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: April 9, 1967

22c PHYSICIAN'S NAME (Type): Wilford D. Meyers MD
22d ADDRESS: 8323 Haddon Drive Takoma Park

23a BURIAL, CREMATION, REMOVAL (Specify): Trans-burial
23b DATE THEREOF: Apr 14, 1967
23c NAME OF CEMETERY OR CREMATORY: De Graff Cemetery
23d LOCATION (City or Town) (County) (State): De Graff Ohio

24 FUNERAL DIRECTOR: John B. Thomas & Thurston Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a REC'D BY REGISTRAR: APR 13 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05523

CERTIFICATE OF DEATH

05522

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
   c. LENGTH OF STAY IN 1b: 4yrs/mo 5da
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN, (If outside corporate limits, write RURAL and give nearest town): Bethesda
   d. STREET ADDRESS: 6302 Marjory Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Eleanar — Middle: Louise — Last: Ursem

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 1967

5. **SEX**: Female

6. **COLOR OR RACE**: W

7. **MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. **DATE OF BIRTH**: Apr. 7, 1884

9. **AGE** (Last birthday): 82 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House Wife

10b. **KIND OF BUSINESS OR INDUSTRY**:

11. **BIRTHPLACE** (County & State, or foreign country): Ohio

12. **CITIZEN OF WHAT COUNTRY?**: U.S.A

13. **FATHER'S NAME**: Wm. A Albriecht

14. **MOTHER'S MAIDEN NAME**: Louise Ropp

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): No

16. **SOCIAL SECURITY NO.**: Unknown

17. **INFORMANT**: Franklin W. Ursom — Son — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonia, (bronchial) — Interval between onset and death: 1wk.
DUE TO (b): Bacterial or viral infection. — 1wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis, Hypertensive CVR disease.

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 19 57 to Apr. 5, 1967, that (I) (we) last saw the deceased alive on Apr. 4, 1967, and that death occurred at 10:20 M, from causes and on the date stated above.

22a. SIGNATURE: Philip H. Varner, M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-5-67

22c. PHYSICIAN'S NAME (Type): PHILIP H. VARNER

22d. ADDRESS: 1063 Old Mill, Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 4-6-67

23c. NAME OF CEMETERY OR CREMATORY: West Park Cemetery

23d. LOCATION (City or Town) (County) (State): Cleveland, Ohio

24. **FUNERAL DIRECTOR** — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05524

CERTIFICATE OF DEATH

05523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA c. LENGTH OF STAY IN 1b: 35 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL	d. STREET ADDRESS: 105 S. SUMMIT AVE e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: JULIA	Middle: LOUISE	Last: VAN METRE	4. DATE OF DEATH	Month: APRIL	Day: 9	Year: 19 67		
5. SEX: FEMALE	6. COLOR OR RACE: CAUC	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 15 SEP 1898	9. AGE (In years last birthday): 68 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): LOUISVILLE, KENTUCKY	12. CITIZEN OF WHAT COUNTRY?: USA						
13. FATHER'S NAME: JAMES THOMAS FORD	14. MOTHER'S MAIDEN NAME: LULA BELLE BROWN								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 213 50 1939	17. INFORMANT: 105 S. SUMMIT AVE. MERLE VAN METRE GAITHERSBURG, MD.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA, LEFT KIDNEY — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6 MAR, 1967, to 9 APR, 1967, that (I) (we) last saw the deceased alive on 9 APR 1967, and that death occurred at 5:15 PM, from causes and on the date stated above.

22a. SIGNATURE: D. K. Roeder M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED: 9 APR 1967		
22c. PHYSICIAN'S NAME (Type): D. K. ROEDER	22d. ADDRESS: NAVAL HSOPITAL, BETHESDA, MD., 20014		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 4-12-67	23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State): ARLINGTON VA.
24. FUNERAL DIRECTOR: GARTNERS FUNERAL HOME — ADDRESS: GAITHERSBURG, MD.	25a. REC'D BY REGISTRAR DATE: APR 13 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05525

CERTIFICATE OF DEATH

05524

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 1172 Rapides Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Anthony — Last: Velotta
4. DATE OF DEATH: Month: April — Day: 6 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 26 August 1901
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Owner
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (County & State or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Velotta
14. MOTHER'S MAIDEN NAME: Josephine Gincto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pseudomonas septicemia — INTERVAL BETWEEN ONSET AND DEATH: 20 hours
DUE TO
(b): Pneumonia — 20 hours
DUE TO
(c): Mycosis Fungoides — 8 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS A TOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 8 March, 1967, to 6 April, 1967, that (X) (we) last saw the deceased alive on 6 April 1967, and that death occurred at 4:05 PM from causes and on the date stated above.

22a. SIGNATURE: C Kierney — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 7 April 1967
22c. PHYSICIAN'S NAME (Type): Carl E. Kierney, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md/

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 4-8-67
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Mem. Park
23d. LOCATION (City or Town) (County) (State): Pineville, Louisiana

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland — ADDRESS
25a. REC'D BY REGISTRAR — DATE: APR 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

M

05526

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05525

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg Rt #2
d. STREET ADDRESS: Box 235 20760
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): ~~Vida~~ First: Alexander Middle: S Last: Vida
4. DATE OF DEATH Month: 4 Day: 12 Year: 1967

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9/25/15
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Istvan Vida
14. MOTHER'S MAIDEN NAME: Tereza Steiyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 224-52-0603
17. INFORMANT: Mrs Margaret Vida, Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12 April, 1967 to 12 April, 1967, that (I) (we) last saw the deceased alive on 12 April 1967 and that death occurred at 6 AM, from causes and on the date stated above.

22a. SIGNATURE: R. Mendelsohn M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 4/12/67
22c. PHYSICIAN'S NAME (Type): Robert Mendelsohn, M.D.
22d. ADDRESS: 1015 Spring St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/15/67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Olin L. Molesworth, ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR: APR 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Medical Examiner A. J. Ball

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05527

CERTIFICATE OF DEATH

05526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 years

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1905 Dennis Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1905 Dennis Avenue

3 NAME OF DECEASED (Type or print): First: MARY — Middle: Jane — Last: VOLMER

4 DATE OF DEATH: Month: April — Day: 7 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: May 20, 1883

9 AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of work ng life even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11 BIRTHPLACE (County & State, or foreign country): Montgomery Co., Missouri

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Daniel B. Brookshire

14. MOTHER'S MAIDEN NAME: Sarah Ann Bartee

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 218-56-5787

17 INFORMANT: Mrs. Audrey Swan — Address: 2425 Eccleston Street Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic H. disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Mar, 1967, to April 7, 1967, that (I) (we) last saw the deceased alive on Mar 28 1967, and that death occurred at 5 A M, from causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler — MD — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 7, 1967

22c PHYSICIAN'S NAME (Type): MARVIN WADLER

22d. ADDRESS: 8218 Wisconsin Av. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr 10, 1967

23c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d LOCATION (City or Town) (County) (State): Rockville Maryland

24. FUNERAL DIRECTOR: C. Vernon Carter — ADDRESS: 8434 Georgia Avenue — Warner E. Pumphrey, Inc. Silver Spring, Md.

25a REC'D BY REGISTRAR: APR 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 ■ 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05527

CERTIFICATE OF DEATH

05528

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 8mo 4dys

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3820 Denfield Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

3. NAME OF DECEASED (Type or print): First: ADA Middle: C. Last: Wade

4. DATE OF DEATH: Month: 4 Day: 8 Year: 1967

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/13/1891

9. AGE (In years last birthday): 75 ~~XXXX~~ yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Eugene Tomlin

14. MOTHER'S MAIDEN NAME: SARAH PARR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 226-24-3560

17. INFORMANT: Mrs. Joseph Bryan Address: 10225 Kensington Pkwy. Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(b): generalized arteriosclerosis — 20 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

H.220

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic cerebral vascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/25, 1966, to 4/8, 1967 that (I) (we) last saw the deceased alive on 4/8 1967, and that death occurred at 2 A M, from causes and on the date stated above.

22a. SIGNATURE: H. E. Kreuzburg M.D ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/8/67

22c. PHYSICIAN'S NAME (Type): H. E. Kreuzburg

22d. ADDRESS: 7852 16th N W Wash D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: Apr 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt Ed Cemetery

23d. LOCATION (City or Town) (County) (State): Batesville, Virginia

24. FUNERAL DIRECTOR: E. Glen Carter Glen Carter ADDRESS: 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. ACCEPTED BY REGISTRAR DATE: APR 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 Film 388 5-11

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05528

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Gen'l. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rte. 5, Box 58B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle HOWARD — Last WALDEN

4. DATE OF DEATH: Month APRIL — Day 11 — Year 1967

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-20-16

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SERVICE ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: PACKAGING

11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) WW II

16. SOCIAL SECURITY NO: 248-10-7043

17. INFORMANT: MRS. JANIE WALDEN (WIFE) — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary thrombosis
DUE TO
(b): Coronary artery heart disease
DUE TO
(c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D. — Address (Street, City, Town, or County): Laytonsville

22. DATE SIGNED: April 11, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-14-67

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEM. PARK

23d. LOCATION (City or Town) (County) (State): SPARTANBURG S.C.

24. FUNERAL DIRECTOR: Robert J. Barranco — ADDRESS: Severna Pk. Md.

25a. RECD BY REGISTRAR DATE: APR 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

ROBERT J. BARRANCO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shou d be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05530 — 05529

1 **PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 25 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CHEVY CHASE NURSING AND Convalescent CENTER

2 **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 1339 FT. STEVENS DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First THOMAS — Middle — Last WALKER

4. **DATE OF DEATH**: Month APRIL — Day 10 — Year 1967

5 SEX: MALE
6. COLOR OR RACE: CAUC
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7 1841
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): TAYLOR
10b KIND OF BUSINESS OR INDUSTRY: CLOTHING
11. BIRTHPLACE (County & State or foreign country): ~~LATVIA~~ LITHUANIA
12 CITIZEN OF WHAT COUNTRY?: LITHUANIA

13. FATHER'S NAME: ABRAHAM WALKER
14. MOTHER'S MAIDEN NAME: ~~MARY SHAPIRO~~ SARAH ALEINSKY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 216-34-1837
17 INFORMANT: MARY WALKER — Address: SAME AS 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Cerebrovascular arteriosclerosis — many years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Stomach — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury n Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-31-, 19 67, to 4/10/, 19 67 that (I) (we) last saw the deceased alive on 4-6- 19 67, and that death occurred at 2:55 M, from causes and on the date stated above

22a SIGNATURE: Arnold A Lear M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-10-67
22c. PHYSICIAN'S NAME (Type): ARNOLD A. LEAR
22d ADDRESS: 1301 18th St. N.W. WASH DC.

23a BURIAL CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4-12-67
23c. NAME OF CEMETERY OR CREMATORY: GEORGIA AV. Cem
23d LOCATION (City or Town) (County) (State): WHEATON, MD

24. FUNERAL DIRECTOR: Goldberg Funeral Home
ADDRESS: 4217 Ga Ave N.W.
25a REC'D BY REGISTRAR DATE: APR 12 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

35531 — 055311

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 1 Main St., Apt. 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Sherrie — Middle: Lynn — Last: Walters

4. **DATE OF DEATH**: Month: April — Day: 19, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1967

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 5 — Min.: 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Maxwell Walters

14. MOTHER'S MAIDEN NAME: Sharon Kay Farmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mother — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 5 hr.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Prematurity
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-19, 19 67, to 4-19, 19 67 that (I) (we) last saw the deceased alive on 4-19 19 67, and that death occurred at 9:57 M, from causes and on the date stated above.

22a. SIGNATURE: David L. Weinstein — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 4/20/67

22c. PHYSICIAN'S NAME (Type): David L. Weinstein, M.D.

22d. ADDRESS: 3222 Davenport St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 4-21-67

23c. NAME OF CEMETERY OR CREMATORY: Washington San & Hospital,

23d. LOCATION (City or Town) (County) (State): Takoma Park, Maryland

24. FUNERAL DIRECTOR — ADDRESS: John Ruffcorn, Washington San. & Hospital

25a. REC'D BY REGISTRAR — DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05532

CERTIFICATE OF DEATH

05531

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 1 Main St., Apt. 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Terri — Middle: Lynn — Last: Walters

4. DATE OF DEATH: Month: April — Day: 19, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1967

9. AGE (In years last birthday) Yrs.

IF UNDER 1 YEAR: Months — Days: 5 — IF UNDER 24 HRS: Hours — Min.: 22

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Maxwell Walters

14. MOTHER'S MAIDEN NAME: Sharon Kay Farmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mother — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary atelectasis
DUE TO (b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 hr.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/19, 1967, to 4/19, 1967, that (I) (we) last saw the deceased alive on 4-19 1967, and that death occurred at 9:50 M, from causes and on the date stated above

22a. SIGNATURE: David L. Weinstein M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 4/20/67

22c. PHYSICIAN'S NAME (Type): David L. WEinstein, M.D.

22d. ADDRESS: 3222 Davenport St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 4-21-67

23c. NAME OF CEMETERY OR CREMATORY: Washington San. & Hospital

23d. LOCATION (City or Town) (County) (State): Takoma Park, Maryland

24. FUNERAL DIRECTOR — ADDRESS: John Ruffcorn, Washington San. & Hospital

25a. RECD BY REGISTRAR DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05533

CERTIFICATE OF DEATH

05532

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 37 hrs

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban -
d. STREET ADDRESS: 6800 Algonquin Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: S. — Last: Ward
4. DATE OF DEATH: Month: April — Day: 26 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-23-85
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone operator
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Eau Claire - Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Anderson
14. MOTHER'S MAIDEN NAME: Elaine Swenson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: daughter — Address: Bethesda.
Elaine C. Dye — 6800 Algonquin Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic cardiovasc. disease — 10 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept., 1960 to April 26, 1967, that (I) (saw) last saw the deceased alive on April 25, 1967, and that death occurred at 2:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen W. Dejter, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: April 26, 1967
22c. PHYSICIAN'S NAME (Type): STEPHEN W. DEJTER, M.D.
22d. ADDRESS: 6719 WILSON LANE, BETHESDA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 4-27-1967
23c. NAME OF CEMETERY OR CREMATORY: Cemetery Sun Set Memorial Park
23d. LOCATION (City or Town) (County) (State): Minneapolis, Minn.

24. FUNERAL DIRECTOR: Joseph Gawlers Sons
ADDRESS: 5130 Wis. Ave. N.W. Wash. D.C.
25a. RECD BY REGISTRAR: DATE MAY 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05534 — 05533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4402 - Ridge Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Dist. of Col. — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington.
d. STREET ADDRESS: 2409 - Wyoming Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Parker — Last: Warner.
4. DATE OF DEATH: Month: 4 — Day: 16 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W		Oct 29, 1876	90 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LIBRARIAN	— — —	WASHINGTON, D.C.	U.S.A.

13. FATHER'S NAME: BRAINARD H. WARNER
14. MOTHER'S MAIDEN NAME: MARY PARKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: 579-60-5634
17. INFORMANT: BRAINARD H. WARNER, III. — Address: 6814 Conn. Ave N.W. Wash. DC

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 Yrs +
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ..... 19..., to 4-16, 1967, that (I) (~~we~~) last saw the deceased alive on 4-15, 1967, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Geo. R. Huffman M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 2401 - DuPont N. Wash D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	4-18-1967	Oak Hill Cemetery	Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. DC.
25a. REC'D BY REGISTRAR DATE: APR 20 1967
25b. REGISTRAR'S SIGNATURE: Jeanne Lange

VR A15 (4)
20M 5-63

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05534

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. + Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 105 Geneva Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Eugene — Middle: Charles — Last: Warren

4 DATE OF DEATH: Month: 4 — Day: 26 — Year: 1967

5 SEX: male

6 COLOR OR RACE: negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-1-1892

9 AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or Foreign country): Charles County, Md

12 CITIZEN OF WHAT COUNTRY? U S

13 FATHER'S NAME: Yancy Warren

14 MOTHER'S MAIDEN NAME: Molly

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes

16 SOCIAL SECURITY NO:

17 INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Arteriosclerotic Heart Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour, a.m. p.m., 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, town or county):

22. DATE SIGNED: 4/27/1967

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 5/1/67

23c NAME OF CEMETERY OR CREMATORY: Ash Memorial Cem.

23d LOCATION (City or Town) (County) (State): Sandy Spring Monty. Md.

24 FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.

25a RECD BY REGISTRAR: DATE: MAY 2 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05536

CERTIFICATE OF DEATH

05535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 13 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, Md.
d. STREET ADDRESS: 213 N. Adams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Bessie; Middle: Theora; Last: Watkins

4 DATE OF DEATH: Month: April; Day: 20; Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-13-92
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James E. Wallach
14. MOTHER'S MAIDEN NAME: Annie Bennett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Daughter, Dorothy Ricketts — Address: 9024 Feilds Rd. Rockville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Neoplasm of liver
DUE TO
(b): Pleural effusion
DUE TO
(c): ? Chronic glomerulonephritis (related)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 5, 1967, to April 19, 1967, that (I) (we) last saw the deceased alive on 4-19 1967, and that death occurred at 4:25 a.m. from causes and on the date stated above

22a. SIGNATURE: L.S. Batman M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-20-67
22c PHYSICIAN'S NAME (Type): L. S. BATMAN M.D.
22d. ADDRESS: DAMASCUS, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4-24-67
23c NAME OF CEMETERY OR CREMATORY: Meth. Church Salem Cemetery
23d LOCATION (City or Town) (County) (State): Cedar Grove, Maryland

24 FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Md.
25a REC'D BY REGISTRAR DATE: APR 24 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05537

CERTIFICATE OF DEATH

05536

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1716 Euclid St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isabel — Middle: HART — Last: WAY

4. DATE OF DEATH: Month: APRIL — Day: 14 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1873

9. AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (County & State, or foreign country): Washington, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Paxton Hart

14. MOTHER'S MAIDEN NAME: Liza Jane Aiken

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Clara Hart Andrews — Address: 8201 Jefferson St. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 MINUTES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CHRONIC MYOCARDITIS —
DUE TO (c): GENERALIZED ARTERIOSCLEROSIS —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from SEPT. 12, 1962, to APRIL 14, 1967, that (I) ~~(we)~~ last saw the deceased alive on APRIL 14, 1967, and that death occurred at 1020 M, from the causes and on the date stated above.

22a. SIGNATURE: Henry Jay London M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/14/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: 5206 NORWAY DR. CHEVY CHASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-18-67

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR ADDRESS: Lee Funeral Home 300 4th St.N.E., Wash.D.C.

25a. REC'D BY REGISTRAR DATE: APR 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05537

05538

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Md
   c. LENGTH OF STAY IN 1b: 13 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Monty.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
   d. STREET ADDRESS: 4111 Plyers Mill Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belmont Nursing Home

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Juanita		Weeden		April	12	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro		[illegible] 13 1900	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Weeden	Ophy Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		215-54-7433		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b): Scleroderma — 25 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7100

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 3/31, 1967, to 4/15, 1967, that (I) (we) last saw the deceased alive on 4/7 1967, and that death occurred at 7:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/12/67

22c. PHYSICIAN'S NAME (Type): C. Hilton — 22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	Apr. 17, 1966	Lincoln Park	Rockville	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert L. Snowden	Rockville, Md.	DATE APR 19 1967	J. Charles Jones

VR A15 (4)
2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05539

CERTIFICATE OF DEATH

05538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 5409 Center St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Joseph — Last: Weide
4. DATE OF DEATH: Month: April — Day: 27 — Year: 1967
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/16/98
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours: 6 — Min: 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: J. B Kendall Co.
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George E. Weide
14. MOTHER'S MAIDEN NAME: Humeke, Wilamina
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes. (If yes give war or dates of service): 1942-45
16. SOCIAL SECURITY NO: - -
17. INFORMANT: Elsie Weide - wife - address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PNEUMOTHORAX, R.L. — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): BULLOUS EMPHYSEMA, SEVERE, BILAT. — many yrs
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 196 to 4-27-, 1967, that (I) (we) last saw the deceased alive on 4-26- 1967, and that death occurred at 7:23 AM, from causes and on the date stated above.

22a. SIGNATURE: Stephen W. Dexter M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-27-67
22c. PHYSICIAN'S NAME (Type): STEPHEN W DEXTER, M.D.
22d. ADDRESS: 6719 WISCONSIN, BETHESDA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-29-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D.C.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: MAY 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Item 18 Film 388 5-8-67 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05539

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 7600 Carroll Avenue
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 4009 Montpelier Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charis — Middle: Elizabeth — Last: Wheeler

4. DATE OF DEATH: Month: 4 — Day: 19 — Year: 1967

5. SEX: Fe

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-22-1900

9. AGE (In years at last birthday): 66 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace G. Welty

14. MOTHER'S MAIDEN NAME: Bertha Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 114-10-0951

17. INFORMANT: Murray J. Wheeler — Address: 4009 Montpelier Road Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial dis. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Mod. cor. art. atherosclerosis — Yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Rogers M.D. — M.D.

EXAMINER'S NAME (Type): John Rogers M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, town, or county): 1919 Eye St. N.W. Washington D.C.

22. DATE SIGNED: 4-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr 31, 1967
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
23d. LOCATION (City or Town) (County) (State): Rutland, Vermont

24. FUNERAL DIRECTOR: Glen Carter — Walter E. Dempsey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05541

CERTIFICATE OF DEATH

05540

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg
d. STREET ADDRESS: Burnt Woods Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leona — Middle: Risher — Last: White

4 DATE OF DEATH: Month: 4 — Day: 14 — Year: 1967

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6/2/84

9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Simon Risher

14. MOTHER'S MAIDEN NAME: Sarah Seibert Risher-Shea

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 190-05-3636

17. INFORMANT — Address: Hospital Records, Olney, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Pul. Emboli. Bilat. — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Thrombosis of Pelvic Veins — hrs-days
DUE TO
(c): Immobility 2° to hip fracture (R) — 2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia - Left Lower Lobe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Fall at home on (R) hip.

20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. Mr 31 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Glenelg (County) Mont (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 4-2, 1967, to 4-14-67, 1967; that (I) (we) last saw the deceased alive on 4-13, 1967, and that death occurred at 8:?? M, from causes and on the date stated above.

22a SIGNATURE: Peter James — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-14-67

22c PHYSICIAN'S NAME (Type): Peter James

22d. ADDRESS: 10620 Georgia Ave., Wheaton, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 4-18-67

23c NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d LOCATION (City or Town) Howard (County) C. (State) Md.

24 FUNERAL DIRECTOR: Harry W. Haight — ADDRESS: Sykesville, Md

25a REC'D BY REGISTRAR DATE: APR 18 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05542 — 05541

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12824 Jingle Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Beverly — Last: Whitley
4. DATE OF DEATH: Month: April — Day: 10 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/25/27
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary (Senate)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Samson Co., No. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William B. Whitley, Sr.
14. MOTHER'S MAIDEN NAME: Lela Gray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes — (If yes give war or dates of service) Navy '45-'52
16. SOCIAL SECURITY NO.: 246 30 9056
17. INFORMANT: Wife, Lois Whitley — Address: 12824 Jingle Ln. S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Artery Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
9. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D
EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Clinton
22. DATE SIGNED: April 11, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/13/67
23c. NAME OF CEMETERY OR CREMATORY: Chapel Hill Mem. Cemetery
23d. LOCATION (City or Town) (County) (State): Chapel Hill North Car.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 131 Rock. Pike Rockville, Md.
25a. RECD BY REGISTRAR: APR 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9 Film #[illegible]

05543

CERTIFICATE OF DEATH

Reg. Dist. No. 05542

1. PLACE OF DEATH a. COUNTY: Montgomery, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Washington b. COUNTY: DC
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7501 Wyndale Road,	d. STREET ADDRESS: 4129 Jenifer St NW — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Isaac — Middle: Ledgewood — Last: Whitney
4. DATE OF DEATH — Month: April — Day: 25 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR (Months, Days)	IF UNDER 24 HRS (Hours, Min)
Male	White	Married	7-13-1880	86 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Woodward & Lothrop Dept. Store	Maine	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Whitney	Madora Tuttle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Address)
No	- - -	577-01-5098A	Mrs. George P. Parton/ 7501 Wyndale Rd. Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Congestive Heart Failure	30 days
DUE TO (b)	Cerebral Hemorrhage	6 weeks
DUE TO (c)	Arteriosclerotic Heart Disease	10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m. | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19[illegible] to April 25, 1967, that I last saw the deceased alive on [illegible], 1967, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William T. Gill M.D. — ADDRESS (Street, city or town, state): 1746 K Street N.W. — DATE SIGNED: 4/26/67

PHYSICIAN'S NAME (Type): Dr. William T. Gill, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4-28-1967	Rock Creek Cemetery	Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.	MAY 2 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

His case was discussed with Dr. [illegible]

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05544

CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): RESMOR SANITARIUM/HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): BETHESDA
d. STREET ADDRESS: 5911 Melvern Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle E — Lost WINDSOR

4. DATE OF DEATH: Month April — Doy 12 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec 17,1887
9. AGE (In yeors lost birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): gov. employee
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & Stote, or foreign country): Pr. Geo. Co., Md
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Everett Windsor
14. MOTHER'S MAIDEN NAME: Fannie Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 217 469 441
17. INFORMANT: Charles E Windsor Jr — Address: Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia
DUE TO
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 1 Week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7, 1966 to 4/12, 1967, that (I) (we) last saw the deceased alive on 4/11 1967, and that death occurred at 3:30 P M, from causes and on the date stated above.

22a. SIGNATURE: Peter P. Andrews — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-12-67
22c. PHYSICIAN'S NAME (Type): Peter P. ANDREWS, M.D.
22d. ADDRESS: 4201 Fessenden ST. N.W. WASH. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Chaptico Cemetery
23d. LOCATION (City or Town) (County) (State): Chaptico Pro Geo Md.

24. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: APR 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (or have removed) carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05545 — 05544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 205 E. Argyle Street Apt #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 205 E. Argyle St. Apt #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Wright

4. DATE OF DEATH: Month: April — Day: 25, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 30, 1896

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: 9 Days: 25 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Wright

14. MOTHER'S MAIDEN NAME: - Sandbower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 577-16-5994

17. INFORMANT: Address: Frenchie M. Wright - wife - same item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY THROMBOSIS	2 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	ARTERIAL HYPERTENSION	20 years
DUE TO (c)	CORONARY ARTERY DISEASE	20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS — CHRONIC RENAL FAILURE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1957, to APRIL 26, 1967, that (I) (we) last saw the deceased alive on APRIL 20 1967, and that death occurred at 4:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: John S. Rosenberger M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 26 1967

22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger

22d. ADDRESS: 310 WEST MONTGOMERY AVE. ROCKVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/28/67

23c. NAME OF CEMETERY OR CREMATORY: Boyds Presbyterian Cem.

23d. LOCATION (City, town or county) (State): Boyds Montg. Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 1331 Rock. Pike Rockville, Md.

25a. REC'D BY REGISTRAR DATE: APR 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Jenkins

VR A15 (4) 20M 1/65